NOTICES OF FINAL RULEMAKING

The Administrative Procedure Act requires the publication of the final rules of the state's agencies. Final rules are those which have appeared in the *Register* first as proposed rules and have been through the formal rulemaking process including approval by the Governor's Regulatory Review Council or the Attorney General. The Secretary of State shall publish the notice along with the Preamble and the full text in the next available issue of the *Register* after the final rules have been submitted for filing and publication.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-22-706	Repeal
R9-22-708	Amend

2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. §§ 36-2903 and 36-2903.01

Implementing statute: A.R.S. §§ 36-2903.01(H), 36-2903.01(J), 36-2904(I), and 36-2908(C)

3. The effective date of the rules:

January 1, 2005

4. A list of all previous notices appearing in the Register addressing the final rule:

Notice of Rulemaking Docket Opening: 10 A.A.R. 1397, April 9, 2004
Notice of Proposed Rulemaking: 10 A.A.R. 3146, August 13, 2004

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name:	Mariaelena Ugarte
Address:	AHCCCS Office of Legal Assistance 701 E. Jefferson, Mail Drop 6200 Phoenix, AZ 85034
Telephone:	(602) 417-4580
Fax:	(602) 253-9115
E-mail:	AHCCCSRules@ahcccs.state.az.us

6. An explanation of the rule, including the agency's reasons for initiating the rule:

The proposed rules were amended as result of a 5-Year-Rule Review, finding that clarification was needed in areas where the rule was outdated, and clarifying verbiage was necessary to explain how payments are made and to whom, for a Native American member.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

No studies were reviewed

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

AHCCCS anticipates minimal impact.

The rule has been revised to repeal outdated information. In addition, a clearer verbiage of how payments for services provided to eligible Native Americans has been clarified. This clarification ensures that all possible scenarios of

when a service is provided to a Native American are covered and explains when prior authorization would be required for payment of a covered service.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

R9-22-708(E) has been reworded to better convey to whom reimbursement is applicable in a certain situation. The wording has been simplified, but does not make any substantive change from the proposed rulemaking. In addition, minor technical and grammatical changes were made.

11. A summary of the comments made regarding the rule and the agency response to them:

None

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

None

13. Incorporations by reference and their location in the rules:

None

14. Was this rule previously adopted as an emergency rule?

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

R9-22-706. ~~Payments by the Administration for Services Provided to Eligible Persons~~ Repealed

R9-22-708. Payments for ~~services provided to eligible~~ Services Provided to Eligible Native Americans ~~residing on reservation~~

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-706. ~~Payments by the Administration for Services Provided to Eligible Persons~~ Repealed

~~**A.** Payment for emergency and medically necessary non-hospital outpatient services. The Administration shall make payments as defined in R9-22-710 for emergency and medically necessary non-hospital services provided to eligible persons.~~

~~1. For dates of service on or before September 30, 1997, emergency services provided to the indigent, the medically needy, and eligible low-income children from the date of notification pursuant to R9-22-313 to the date of enrollment with a prepaid capitated contractor shall be paid at the capped fee-for-service rate or billed charges, whichever is lower. On the date of notification to the AHCCCS Administration, the county shall notify the AHCCCS Administration of the amount of medical expenses necessary to satisfy the spend down requirement of R9-22-321 and incurred by the household, if any, during the period of the Administration's retroactive liability.~~

~~2. For dates of service on or before September 30, 1997, medically necessary services provided to categorically eligible persons and eligible assistance children from the effective date of eligibility to the date of enrollment with a prepaid capitated contractor shall be paid at the capped fee-for-service rate or billed charges, whichever is less.~~

~~**B.** Indian Health Service. The Administration shall pay IHS the all-inclusive inpatient, outpatient, or ambulatory surgery rates published in the Federal Register for AHCCCS-covered services provided in IHS facilities. Except as provided in R9-22-708, IHS medical service referrals for eligible Native Americans made to off-reservation contractors, providers, noncontracting providers, or nonproviders shall be prior authorized.~~

R9-22-708. Payment for ~~services provided to eligible~~ Services Provided to Eligible Native Americans ~~Residing on Reservation~~

~~**A.** Categorically eligible Native Americans may enroll with a contractor in accordance with Article 3 of these rules.~~

~~**B.** Categorically eligible Native Americans who do not select an AHCCCS contractor and indigent and medically needy Native Americans shall be assigned in accordance with Article 3 of these rules.~~

~~**C.** Providers and nonproviders shall comply with prior authorization requirements of the Administration, as set forth in Article 2 of these rules, and of contractors.~~

A. For purposes of this article "IHS enrolled" or "enrolled with IHS" means a Native American who has elected to receive

covered services through IHS instead of a contractor.

B. For a Native American who is enrolled with IHS, AHCCCS shall pay IHS the most recent all-inclusive inpatient, outpatient or ambulatory surgery rates published by Health and Human Services (HHS) in the Federal Register, or a separately contracted rate with IHS, for AHCCCS-covered services provided in an IHS facility. AHCCCS shall reimburse providers for the Medicare coinsurance and deductible amounts required to be paid by the Administration or contractor in Chapter 29, Article 3 of this Title.

C. When IHS refers a Native American enrolled with IHS to a provider other than an IHS or tribal facility, the provider to whom the referral is made shall obtain prior authorization from AHCCCS for services as required under Articles 2, 7 or 12 of this Chapter.

D. ~~Contractors other than the Indian Health Service providing care to eligible Native Americans shall be reimbursed on a capitation basis.~~ For a Native American enrolled with a contractor, AHCCCS shall pay the contractor a monthly capitation payment.

E. Once a Native American ~~has enrolled~~ enrolls with a contractor, ~~no~~ AHCCCS shall not reimburse any provider other than IHS or a Tribal facility. ~~referral care rendered after the date of enrollment shall be reimbursable by a contractor unless the care is rendered pursuant to a referral or prior authorization made by the contractor of record.~~

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ARIZONA LONG-TERM CARE SYSTEM

PREAMBLE

1. Sections Affected | **Rulemaking Action**
R9-28-706 | Amend

2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):
Authorizing statute: A.R.S. §§ 36-2903 and 36-2903.01
Implementing statute: A.R.S. §§ 36-2903.01(H), 36-2903.01(J), 36-2904(I), 36-2908(C), 36-2932

3. The effective date of the rules:
January 1, 2005

4. A list of all previous notices appearing in the Register addressing the final rule:
Notice of Rulemaking Docket Opening: 10 A.A.R. 1398, April 9, 2004
Notice of Proposed Rulemaking: 10 A.A.R. 3156, August 13, 2004

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name:	Mariaelena Ugarte
Address:	AHCCCS Office of Legal Assistance 701 E. Jefferson, Mail Drop 6200 Phoenix, AZ 85034
Telephone:	(602) 417-4580
Fax:	(602) 253-9115
E-mail:	AHCCCSRules@ahcccs.state.az.us

6. An explanation of the rule, including the agency's reasons for initiating the rule:
The proposed rules were amended as a result of a 5-Year-Rule Review. During the process of reviewing the rule it was found that the reference to another Chapter and Section needed to be updated, since that referenced section is being renumbered in another rule package.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:
No studies were reviewed

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previ-

ous grant of authority of a political subdivision of this state:
Not applicable

9. The summary of the economic, small business, and consumer impact:
AHCCCS anticipates minimal impact to the public because the rule changes are only technical or grammatical changes and do not change the current business practice.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):
The Administration determined that R9-28-706(C) would be better located in R9-22-712, because it applies to inpatient and both acute and long-term care programs. The Administration deleted R9-28-706(C) because it intends to move the substance of that subsection to R9-22-712 (for which the Administration currently has a docket open).

In addition, minor technical and grammatical changes were made.

11. A summary of the comments made regarding the rule and the agency response to them:
None

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:
None

13. Incorporations by reference and their location in the rules:
None

14. Was this rule previously adopted as an emergency rule?
No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ARIZONA LONG-TERM CARE SYSTEM

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-28-706. Payments by the Administration for Services Provided to an Eligible ~~Persons~~ Person

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-28-706. Payments by the Administration for Services Provided to an Eligible ~~Persons~~ Person

A. Payment for medically necessary outpatient services.

1. The Administration shall pay for medically necessary outpatient services provided to an eligible ~~persons~~ person from the effective date of eligibility to the date of enrollment with a program contractor at the negotiated rate, capped fee-for-service rate, or in the amount of the billed charges, whichever is lowest.
2. ~~Eligible persons~~ An eligible person residing in ~~areas~~ an area that ~~are~~ is not served by a program ~~contractors~~ contractor ~~shall be~~ is eligible for ALTCS-covered services. The Administration shall make payment for medically necessary outpatient services provided to ~~these individuals~~ the person at the negotiated rate, capped fee-for-service rate, or in the amount of the billed charges, whichever is lowest.
3. The Administration shall pay for medically necessary outpatient services provided to an eligible ~~persons~~ person by an out-of-state ~~providers~~ provider at the capped fee-for-service rate under ~~R9-28-708~~ this Article or the Medicaid rate that is in effect for the state in which the provider is located at the time services are provided ~~in the state in which the provider is located~~, whichever is lower.

B. The Administration shall make payment in accordance with ~~A.A.C. R9-22-712~~ 9 A.A.C. 22, Article 7 for covered hospital services provided to an eligible ~~persons~~ person on or after March 1, 1993.

~~**C.** Limitation on payment for hospital services. The Administration may limit payment for hospital services furnished to hospital inpatients who require a lower covered level of care, such as nursing facility services, to the cost of the lower or alternative level of care, when the Director or designee determines the less costly alternative could and should have been used by a hospital.~~

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM CHILDREN'S HEALTH INSURANCE PROGRAM

PREAMBLE

1. Sections Affected | **Rulemaking Action**
R9-31-1616 | Amend

2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. §§ 36-2903 and 36-2903.01

Implementing statute: A.R.S. §§ 36-2903.01(H), 36-2903.01(J), 36-2904(I), and 36-2908(C)

3. The effective date of the rules:

January 1, 2005

4. A list of all previous notices appearing in the Register addressing the final rule:

Notice of Rulemaking Docket Opening: 10 A.A.R. 1399, April 9, 2004
Notice of Proposed Rulemaking: 10 A.A.R. 3159, August 13, 2004

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Mariaelena Ugarte

Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4580

Fax: (602) 253-9115

E-mail: AHCCCSRules@ahcccs.state.az.us

6. An explanation of the rule, including the agency's reasons for initiating the rule:

The rules are being amended as result of a rule review completed in other Chapters pertaining to the same subject matter.

During the review process it was found that clarification was needed in areas where the rules were outdated, and clarifying verbiage was necessary to explain how payments are made and to whom, for a Native American member.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

No studies were reviewed.

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

AHCCCS anticipates minimal impact to the public because the rule changes are only technical or grammatical changes and do not change the current business practice.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

R9-31-1616(A), the Administration clarified that the extent of financial liability for a contractor is the same as for the Administration.

R9-31-1616(E) was deleted because it addressed a specific situation that no longer exists and it is not expected to occur in the future. It was also unclear whether the Administration had the statutory authority to enforce the provision.

In addition, minor technical and grammatical changes were made.

11. A summary of the comments made regarding the rule and the agency response to them:
None

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:
None

13. Incorporations by reference and their location in the rules:
None

14. Was this rule previously adopted as an emergency rule?
No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM CHILDREN'S HEALTH INSURANCE PROGRAM

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

Section
R9-31-1616. Standards for Payments

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

R9-31-1616. Standards for Payments

A. The Administration ~~shall bear no liability for providing covered services to or completing a plan of treatment for any~~ has no financial responsibility for services provided to a member beyond the effective date of termination of a member's eligibility~~, or enrollment as specified in A.R.S. § 36-2987.~~
A contractor has no financial responsibility for services provided to a member beyond the last date of enrollment except as provided in Articles 2 and 5 of Chapter 22 of this Title, and as specified in contract.

~~**B.** The Administration shall make payments to the IHS, a Tribal Facility, or under referral from an IHS or a Tribal Facility provider based on the Administration's capped fee schedule as specified in A.A.C. R9-22-710 for outpatient services.~~

~~**C.** The Administration shall make payments to the IHS, or a Tribal Facility based on the all-inclusive inpatient rates published in the Federal Register.~~

~~**C.**~~**B.** The Administration shall make payments to IHS or a Tribal Facility as required under A.R.S. 36-2987(A).

~~**D.**~~**C.** The Administration shall pay inpatient and outpatient hospital services ~~provided~~ rendered by a provider under referral from the IHS or a Tribal Facility provider based on A.R.S. §§ 36-2987, 36-2904, 36-2903.01, ~~and~~ A.A.C. R9-22-712, and A.A.C. R9-22-718, as applicable. Discounts and penalties ~~shall be as~~ are specified in A.R.S. § 36-2987(C).

~~**E.** The Administration shall bear no liability for a subcontract that the IHS or a Tribal Facility executes with other parties for the provision of administrative or management services, medical services, or covered health care services, or for any other purpose. The IHS or a Tribal Facility shall indemnify and hold the Administration harmless from any and all liability arising from the IHS or a Tribal Facility's subcontracts, shall bear all costs of defense of any litigation over the liability, and shall satisfy in full any judgment entered against the Administration in litigation involving the IHS or a Tribal Facility's subcontracts~~

NOTICE OF FINAL RULEMAKING

TITLE 20. COMMERCE, BANKING, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

PREAMBLE

1. Sections Affected	**Rulemaking Action**
R20-6-1001	Amend
R20-6-1002	Amend
R20-6-1003	Amend

R20-6-1004	Amend
R20-6-1005	Renumber
R20-6-1005	New Section
R20-6-1006	Renumber
R20-6-1006	Amend
R20-6-1007	Renumber
R20-6-1007	Amend
R20-6-1008	Renumber
R20-6-1008	New Section
R20-6-1009	Renumber
R20-6-1009	New Section
R20-6-1010	Renumber
R20-6-1010	Amend
R20-6-1011	Renumber
R20-6-1011	Amend
R20-6-1012	Renumber
R20-6-1012	Amend
R20-6-1013	Renumber
R20-6-1013	Amend
R20-6-1014	Repeal
R20-6-1014	Renumber
R20-6-1014	Amend
R20-6-1015	Renumber
R20-6-1015	New Section
R20-6-1016	Renumber
R20-6-1016	Amend
R20-6-1017	Renumber
R20-6-1017	Amend
R20-6-1018	New Section
R20-6-1019	New Section
R20-6-1020	New Section
R20-6-1021	New Section
R20-6-1022	Renumber
R20-6-1022	Amend
R20-6-1023	Renumber
R20-6-1023	Amend
R20-6-1024	New Section
Appendix A	Renumber
Appendix A	New Section
Appendix B	Renumber
Appendix B	New Section
Appendix C	Renumber
Appendix C	Amend
Appendix D	Renumber
Appendix D	Amend
Appendix E	New Section
Appendix F	New Section
Appendix G	New Section
Appendix H	New Section
Appendix I	New Section
Appendix J	New Section

2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statutes: A.R.S. §§ 20-143, 20-1691.02

Implementing statutes: A.R.S.§§ 20-143, 20-1691.01, 20-1691.04, 20-1691.06, 20-1691.11

3. The effective date of the rules:

January 3, 2005

4. List of all previous notices appearing in the Register addressing the proposed rules:

Notice of Rulemaking Docket Opening: 10 A.A.R. 323, January 23, 2004

Notice of Proposed Rulemaking: 10 A.A.R. 1084, March 26, 2004

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Margaret McClelland

Address: Department of Insurance
2910 N. 44th St., Second Floor
Phoenix, AZ 85018

Telephone: (602) 912-8456

Fax: (602) 912-8452

6. An explanation of the rule, including the agency's reasons for initiating the rule:

This rulemaking carries out the mandates of Laws 2003, Ch. 133, which became effective on September 18, 2003 and amended the Arizona long-term care insurance statutes for closer conformity with the National Association of Insurance Commissioners' (NAIC) Long-Term Care (LTC) Insurance Model Act and Regulations. The NAIC LTC Insurance Model Regulation is already in effect in a number of states and this rulemaking will result in greater uniformity for insurers that operate in 48 other states and may obviate the need to re-file and seek approval for forms used after these rules become effective in Arizona.

7. A reference to any study relevant to the rules that the agency reviewed and either proposes to rely on in its evaluation of or justification for the rules or proposes to rely on in its evaluation of or justification for the rules, where the public may obtain or review the study, all data underlying each study, any analysis of each or study and other supporting material:

None

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business and consumer impact:

The NAIC LTC Insurance Model Regulation is already in effect in 48 states and this rulemaking will result in greater uniformity for insurers that operate in Arizona and those other states and may obviate the need to re-file and seek approval for forms used after these rules become effective in Arizona. The cost of compliance in Arizona is will be greatly reduced by the predictability and uniformity of the requirements in these rules. What is required in these rules is generally already required to be provided in 48 other states, which means that generally, what is already provided for those other states will only need to be duplicated for Arizona. There are currently 65 companies selling long-term care insurance in Arizona.

Long-term care insurers will have some increased disclosure requirements under these rules. As a result, the insurers may have to produce disclosure documents that they do not currently produce and may incur additional costs for printing, copying, and mailing. The economic impact per policyholder will likely be insignificant, and the overall economic impact as a result of this rulemaking should be minimal to moderate. Additionally, under these rules, insurers will have to provide more information to justify rate increases. This could result in less frequent rate increases.

The consumers involved are consumers of long-term care insurance. Policyholders may have somewhat higher rates initially, but, as a result of these rules, rates for long-term care insurance should stabilize with a resulting cost savings over the life of the policy. The rules will provide protections to the consumer through better disclosure of information about the insurer and enhanced suitability requirements. Consumers will have an unquantifiable benefit of being more aware of what they are purchasing, making them better able to make decisions about their purchase and making them better-protected consumers.

Few small businesses will be directly impacted by this rule. The insurers that offer long-term care insurance are large corporations that can absorb the costs of paying out long-term care benefits. There may be some small business who might benefit indirectly from additional printing and copying opportunities, but is it possible that many insurers will print and copy in-house. Some consulting actuarial businesses may receive additional business as a result of these rules.

The Department does not believe that small businesses will be directly impacted by this rule, therefore, the Department does not believe it is necessary to reduce the impact on small businesses.

There will be a minimal economic impact on the Department, the Secretary of State and the Governor’s Regulatory Review Council for costs associated with the rulemaking process.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

R20-6-1002(4) is amended to correct the citation A.R.S. § 20-2102(18) to 20-2102(19).

R20-6-1002(5) is amended to correct the citation A.R.S. § 20-2102(21) to 20-2102(22).

R20-6-1003(A) is revised to add the following:

4. “Agent” means a insurance producer as defined in A.R.S. § 20-281(5).

R20-6-1003(A)(9) is revised as follows:

"Eating" means feeding oneself by getting food into the body from a receptacle such as a plate, ~~or~~ cup, or table, or by a feeding tube or intravenously.

R20-6-1003(A)(11) is revised as follows:

"Hands-on assistance" means physical help to an individual who could not perform a ~~particular~~ an activity of daily living without help from another individual, and includes minimal, moderate, or maximal help.

R20-6-1005(E) is amended to add, "The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant."

The second sentence of R20-6-1006(D)(2) is revised as follows:

> If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall ~~also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75 and 85 for benefit increases~~ provide a revised schedule of attained age premiums.

R20-6-1007(A) is amended to restore: "Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long term care insurance policy."

R20-6-1017(B)(4) is revised to delete "material" to be consistent with A.R.S. § 20-443.

The term "producer" is changed to "insurance producer" throughout the rules to be consistent with the defined term in A.R.S. § 20-281(5).

The Department made non-substantive changes to correct Section numbering and headings.

Additional non-substantive changes were made in response to comments from the G.R.R.C. staff.

11. A summary of the comments made regarding the rules and the agency responses to them:

The Department held an oral proceeding and received oral comments from two persons and then follow-up comment letters from those same persons, on behalf of American Council of Life Insurers (ACLI) and the other on behalf of America's Health Insurance Plans. Generally, the oral comments and the letters request various revisions for purposes of conformity with the NAIC Model Long-Term Care Insurance Regulation (Model).

1. Comment: The proposed regulation uses the term "producer" instead of "agent" which is in the Model Act and on various ACLI forms. The ACLI requests, to save the cost of printing new forms, that the Department allow continued use of the terms "agent" and "accident and sickness" until the forms are reprinted or upon filing a new product.
   Response: The Department will continue to accept forms with the terms "agent" and "accident and sickness" until current forms run out, or for one year from the effective date of these rules, whichever is sooner. Additionally, the person who has been typically known in the industry as an agent, is currently defined in Arizona as an "insurance producer" in A.R.S. § 20-487(6). However, because the term "agent" is a term that is well established and understood in the industry, particularly by senior citizens who are the primary consumers of long-term care insurance, and because the term "agent" is more widely used in the industry and on insurance forms, forms required by the NAIC, and documents in general, the Department will add a definition that defines an "agent" to mean an "insurance producer" to reduce confusion among consumers.
2. Comment: It appears that the proposed rules have lessened the implementation period by 60 days or two months. The ACLI requests clarification that the implementation period will be the same as outlined in the Model Act.
   Response: The NAIC model rules provide for various implementation time periods for several sections of the rules. The Department rules shorten those time periods by two months, or 60 days because, under the Arizona Administrative Procedures Act, there is a 60-day delay in effectiveness of final rules after they are filed with the Office of the Secretary of State (SOS). Even though the rules do not become effective for 60 days after filing with the SOS, there will be no changes made to the rules after filing, therefore, the insurers will know exactly the requirements of the final rules and can use those two months of delay in effectiveness to begin any implementation processes they need to begin. The Department does not believe there is any need to extend the implementation period any longer, particularly in light of the Department's decision to accept forms as discussed in the response to comment #1.
3. Comment: ACLI requests that, in the case of a discrepancy between the Arizona rules and the Model, the Arizona proposed rules be revised to be consistent with the Model.
   Response: The Department has used the Model to conform the rules to the Model as closely as practicable. The Department believes that conformity with the Model is important for consistency with rules put in place by other states and to avoid confusion and expense as a result of Arizona rules being different from those of the 48 states that have adopted the Model. There are, however, a very few instances where Arizona law, the director's interest of protecting Arizona citizens, or other overriding interests require that Arizona rule language vary from the Model. But, overall, Arizona will maintain consistency with the Model.
4. Comment: The Department omitted language from the introductory section of the Model that states that the purpose of the regulation is to implement the NAIC Long-Term Care Insurance Model Act (Act). ACLI requests that Arizona include consistent language in the rules.
   Response: The Department did not include that language because that language specified is introductory language,

not regulatory language, and it would not be appropriate to include it as regulatory language in the rules. The preamble of this rulemaking does acknowledge that the rules are amended for closer conformity with the Act. That is the more appropriate place for that language.

5. Comment: The reference for the definition of "personal information" should be changed from A.R.S. § 20-2102(18) to 20-2102(19).
   Response: The Department agrees and the rule is amended accordingly.
6. Comment: Some aspects of the Model definition of "similar policy forms" are omitted in the Arizona definition found in A.R.S. § 20-2102(22).
   Response: The aspects that were omitted relate to group rates. Arizona has no authority to regulate group rates, therefore, no authority to include such references in the definition.
7. Comment: Arizona's definition of "cognitive impairment" in R20-6-1003(A)(6) should read "time *or* place", rather than "time *and* place", to be consistent with the Model.
   Response: The Model actually reads "place and time"; however, the Department agrees that the language should read "place, or time" and the rule is revised accordingly.
8. Comment: The term "particular activity" in the definition of "hands on assistance" is not defined; whereas, "activity of daily living" is in R20-6-1003(1). The definition of "hands on assistance" should be revised to be consistent with the Model.
   Response: The Department will revise R20-6-1003(11) for consistency with the Model as follows:
   "Hands-on assistance" means physical help to an individual who could not perform ~~a particular~~ an activity of daily living without help from another individual, and includes minimal, moderate, or maximal help.
9. Comment: Arizona's definition of "eating" in R20-6-1003(A)(8) does not include the term *table* as a receptacle as the Model does. Requests that Arizona language be consistent.
   Response: The rule is revised for consistency with the Model as follows:
   "Eating" means feeding oneself by getting food into the body from a receptacle such as a plate, ~~or~~ cup, or table, or by a feeding tube or intravenously.
10. Comment: R20-6-1004(E)(3) should be revised to include the phrase "for at least six months immediately prior to termination" to be consistent with the Model.
    Response: The Department disagrees that this phrase should be added. This requirement would add a requirement that would be more restrictive to persons with long-term care insurance than persons with other types of insurance under Title 20 that do not require a minimum period of coverage, such as conversions and continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (Public Law 99-272).
11. Comment: R20-6-1004 (E)(4) should be revised to restore the phrase "including, but not limited to" in the text of this subsection. The commenter believes the omission restricts comparison to the items listed.
    Response: The Department deleted that phrase to comply with the current rule writing standards set forth in the *Arizona Rulemaking Manual*. The deletion of this phase should not affect the overall consistency of this rulemaking with the model.
12. Comment: R20-6-1004(H)(1)(a) should be revised to remove the requirement that an enrollee be provided verification of enrollment information within three business days to be consistent with the Model which does not place a specific time limit on the group policyholder or insurer for providing enrollment verification.
    Response: The Department believes that setting a time limit for verification of enrollment information is a reasonable practice and protective of the public, particularly senior citizens who are consumers of long-term care insurance. This is not an unusual practice, as other types of insurance have such a requirement. The Department will continue to require that this verification, however, the rule will be amended to allow that verification be provided to the enrollee within five business days of enrollment, instead of three days. The requirement of the verification remains protective of the public and the Department does not believe that the additional two days harms the interests of the insured.
13. Comment: The Department should add to R20-6-1004(I) the following language from the Model:
    A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities
    Response: A.R.S. § 20-1691.03(C) requires that the policy provide long-term care coverage for at least 24 consecutive months. In this instance, if the Department adopted the Model language, the language would be in conflict with the statute.
14. Comment: R20-6-1005(D) should be revised to exclude the following sentence:
    An insured may add a designated recipient or change a designated recipient at any time by notifying the insurer in writing, and providing the name and address for the new designated recipient.
    The Department should add Model language that states: "The insurer shall notify the insured of the right to change this written designation, no less often than once every two years."

Response: The Department believes that the Model language is too restrictive and would not allow insureds to make changes as situations arise necessitating change. Department believes the language in the rules is necessary for the protection of insureds, particularly elderly insureds.

15. Comment: The following sentence should be added to R20-6-1005(E) for consistency with the Model: "The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant."
    Response: The Department will make this change for consistency with the Model.
16. Comment: The rate stabilization will operate to determine the appropriate premiums and it is difficult to predict the premiums based upon these requirements. The ACLI requests the second sentence in R20-6-1006(D)(2) be consistent with the Model.
    Response: This second sentence applies only to attained-age premiums. If premiums are to be increased or added, the insurer should be required to provide a revised schedule of attained-age premiums. This requirement for an attained-age premium schedule is not a new provision as it is required at the time of original filing policy. The second sentence of R20-6-1006(D)(2) is revised for clarity as follows:
    If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall ~~also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75 and 85 for benefit increases~~ provide a revised schedule of attained-age premiums.
17. Comment: Arizona should restore the following language to R20-6-1007(A) for consistency with the Model: "Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long term care insurance policy."
    Response: The Department has restored the language to R20-6-1007(A) for consistency with the Model in response to this comment.
18. Comment: R20-6-1009(B) should be revised to allow an insurer 30 days before a form is available for sale to provide disclosure documents and actuarial certification, rather than at the time of filing with the Department.
    Response: The Department disagrees. This information must be provided to the Department at the time of filing under A.R.S. § 20-1691.08, which requires the Director to approve or disapprove the filing within 30 days of receipt of the filing or the filing is deemed approved. Disclosure documents and an actuarial certification need to be reviewed as part of the approval process, so they must be included with the initial filing in light of the minimal time-frame for review of the filing.
19. Comment: The first sentence in R20-6-1009(C) should be revised to change "may require" to "may request".
    Response: The Department disagrees. If the Department needs information from an insurer because it is necessary for the protection of the consumers, or to otherwise carry out Department mandates, the Department must be able to require that the information be provided. No change.
20. Comment: R20-6-1009(B) should be made consistent with the Model language in Section 10(B) and 10(C)(2). The Model provides that material must be provided 30 days before the form is available for sale; whereas, the rule makes the information due at the time of filing.
    Response: The Department will remain consistent with statutory requirements in A.R.S. § 20-1691.08 and require that the information be provided at the time of filing.
21. Comment: R20-6-1014(C) should be revised to include Model language that states: Any policy illustration that meets the applicable requirements of the NAIC Life Insurance Illustrations Model Regulation." The commenter states that this is another condition that determines compliance for policies where benefits are through acceleration.
    Response: This language would be appropriate in a state that has adopted the NAIC Life Insurance Illustrations Model Regulation which is different from the model rules being considered here. Three bills have been submitted in the past to the Arizona legislature for consideration of adoption of this model regulation, but to date, Arizona has not adopted it, therefore, it would not be appropriate to add this language to this rule.
22. Comment: R20-6-1015 is missing the Model provision for additional time for new certificates on existing group policies to become subject to the rate increase rules; the rules do not apply until the policy anniversary following a date one year after the adoption date.
    Response: That provision relates to group insurance rates. These rules do not regulate group insurance rates.
23. Comment: R20-6-1015 is missing the Model provision that states "In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates."
    Response: That provision relates to group insurance rates. These rules do not regulate group insurance rates.
24. Comment: R20-6-1015(G) omits the adverb "adequately" as found in the Model.
    Response: The word "adequately" is omitted to be consistent with rulewriting standards in the *Arizona Rulemaking Manual.*
25. Comment: The rules do not contain a Model provision regarding group insurance that would provide for an exception when the terms of R20-6-1015(G) and (I) are met.
    Response: That provision relates to group insurance rates. These rules do not regulate group insurance rates.

26. Comment: R20-6-1017(A)(4) does not contain the Model exception that provides, in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required.
    Response: The Department believes that this inquiry is necessary for consumer protection, and the fact that this is a qualified long-term care contract does not mean that those consumers are worthy of less protection.
27. Comment: The rules omit Model language relative to filing requirements for advertising.
    Response: In Arizona, A.R.S. § 20-1110(E) governs filing requirements for advertisement, therefore, the Department has not included the Model requirements.
28. Comment: AHIP requests clarification whether, when insurers are required to file new disclosure documents, they also be required to provide an actuarial certification for approved policy forms if the rates on the forms do not change? AHIP requests that Arizona not require an actuarial certification for policy forms without new rates if the forms were actuarially certified upon initial filing.
    Response: It is unclear what disclosure documents are being referred to. If the commenter means forms such as appendices at the end of the rules, actuarial certification will not be required as long as policy forms and rates were previously approved and the forms and rates remain unchanged. However, if these are new policy forms or filings of rate increases, actuarial certification will be required.
29. Comment: AHIP requests clarification whether the Department will require an endorsement to implement the provision under R20-6-1004(C) regarding extension of benefits. AHIP requests no endorsement and that the language be identical to the Model and that no endorsement be required if the policy provides that the extension of benefits upon lapse may be limited to the policy period or to payment of the maximum benefits.
    Response: Without reviewing the language in these policies, the Department is unable to determine whether the language in the policy is the same. It is very important that this information be disclosed to policyholders, so, in the interest of consumer protection and uniformity, the Department will require an endorsement.

12. Any other matters prescribed by the statute that are applicable to the specific agency or to any specific rules or class of rules:

Not applicable

13. Incorporations by reference and their location in the rule:

Not applicable

14. Were the rules previously made as emergency rules?

No

15. The full text of the rules follows:

TITLE 20. COMMERCE, BANKING, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

ARTICLE 10. LONG-TERM CARE INSURANCE

Section
R20-6-1001. Applicability and Scope
R20-6-1002. Definitions
R20-6-1003. Policy ~~Definitions~~ Terms
R20-6-1004. Required Policy Provisions ~~and Practices: Renewability; Exclusions and Limitations; Extension of Benefits Continuation or Conversion; Discontinuance and Replacement; Home Health Care~~
R20-6-1005. Unintentional Lapse
~~R20-6-1005.~~R20-6-1006. Inflation Protection
~~R20-6-1006.~~R20-6-1007. Required Disclosure Provisions
R20-6-1008. Required Disclosure of Rating Practices to Consumers
R20-6-1009. Initial Filing Requirements
~~R20-6-1007.~~R20-6-1010. Requirements for Application Forms and Replacement Coverage
~~R20-6-1008.~~R20-6-1011. Prohibition Against Post-claims Underwriting
~~R20-6-1009.~~R20-6-1012. Discretionary Powers of Director
~~R20-6-1010.~~R20-6-1013. Reserve Standards
~~R20-6-1014. Filing Requirements for Advertising~~
~~R20-6-1011.~~R20-6-1014. Loss Ratio
R20-6-1015. Premium Rate Schedule Increase
~~R20-6-1012.~~R20-6-1016. Filing ~~Requirement~~ Requirements for Group ~~Policy~~ Policies ~~Issued in Another State~~
~~R20-6-1013.~~R20-6-1017. Standards for Marketing

ARTICLE 10. LONG-TERM CARE INSURANCE

R20-6-1001. Applicability and Scope

Except as otherwise specifically provided, this Article applies to all long-term care insurance policies delivered or issued for delivery in this state ~~on or after the effective date hereof by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health care services organizations and all similar organizations~~.

R20-6-1002. Definitions

~~A. For purposes of~~ The definitions in A.R.S. § 20-1691 and the following definitions apply in this Article~~, the terms "long-term care insurance", "group long-term care insurance", "director", "applicant", "policy" and "certificate" shall have the meanings as set forth in A.R.S. § 20-1691~~.

1. "Incidental" means that the value of the long-term care benefits provided is less than 10% of the total value of the benefits provided over the life of the policy, with value measured as of the date of issue.
2. "Long-term care benefit classification" means one of the following:
   a. Institutional long-term care – benefits only;
   b. Non-institutional long-term care – benefits only; or
   c. Comprehensive long-term care benefits.

~~B.~~3. ~~A~~ "~~managed~~ Managed care plan" ~~is~~ means a health care or assisted living agreement designed to coordinate patient care or control costs through utilization review, case management, ~~or~~ use of specific provider networks, or a combination of these methods.

4. "Personal information" has the same meaning prescribed in A.R.S. § 20-2102(19).
5. "Privileged information" has the same meaning prescribed in A.R.S. § 20-2102(22).
6. "Qualified actuary" means a member in good standing of the American Academy of Actuaries.
7. "Similar policy forms" means all long-term care insurance policies and certificates that are issued by a particular insurer and that have the same long-term care benefit classification as a policy form being reviewed.

R20-6-1003. Policy ~~Definitions~~ Terms

A. ~~No~~ A long-term care insurance policy delivered or issued for delivery in this state shall not use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

1. "Activities of daily living" means eating, toileting, transferring, bathing, dressing, or continence.

~~1.~~2. "Acute condition" means that ~~the~~ an individual is medically unstable~~. Such an individual~~ and requires frequent monitoring by medical professionals, such as physicians and registered nurses, ~~in order~~ to maintain ~~his or her~~ the individual's health status.

3. "Adult day care" means a program of social and health-related services for six or more individuals, that is provided during the day in a community group setting, for the purpose of supporting frail, impaired, elderly, or other disabled adults who can benefit from the services and care in a setting outside the home.
4. "Agent" means an insurance producer as defined in A.R.S. § 20-281(5).
5. "Bathing" means washing oneself by sponge bath, or in a tub or shower, and includes the act of getting in and out of the tub or shower.
6. "Cognitive impairment' means a deficiency in a person's:
   a. Short or long-term memory;
   b. Orientation as to person, place, or time;

c. Deductive or abstract reasoning; or
d. Judgment as it relates to safety awareness.

7. "Continence" means the ability to maintain control of bowel and bladder function, or when unable to maintain control, the ability to perform associated personal hygiene, such as caring for a catheter or colostomy bag.
8. "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
9. "Eating" means feeding oneself by getting food into the body from a receptacle such as a plate, cup, or table, or by a feeding tube or intravenously.
~~2.~~10. "Guaranteed renewable" means the insured has the right to continue ~~the~~ a long-term-care insurance policy in force by the timely payment of premiums and ~~when~~ the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that the insurer may revise rates ~~may be revised by the insurer~~ on a class basis.
11. "Hands-on assistance" means physical help to an individual who could not perform an activity of daily living without help from another individual, and includes minimal, moderate, or maximal help.
~~3.~~12. "Home health services" means ~~those~~ the services described A.R.S. § 36-151.
13. "Level premium" means that an insurer does not have any right to change the premium, even at renewal.
~~4.~~14. "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.
~~5. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.~~
~~6.~~15. "Noncancellable" means the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally cancel or make any change in any provision of the insurance or in the premium rate.
16. "Personal care" means the provision of hands-on assistance to help an individual with activities of daily living in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.
17. "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing tasks associated with personal hygiene.
18. "Transferring" means moving into or out of a bed, chair, or wheelchair.

B. Any long-term care policy delivered or issued for delivery in this state shall include the following policy terms and provisions as specified in this subsection:

1. "Home care" shall be defined in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.
2. "Intermediate care" shall be defined in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.
3. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.
4. "Skilled nursing care," ~~"intermediate care," "personal care," "home care," and other services~~ shall be defined in relation to the level of skill required, the nature of the care and the setting in which care is delivered.

~~C~~5. ~~All~~ Service providers ~~of services~~, including ~~but not limited to~~ "skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home," ~~,~~ "personal care facility," and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services~~. The definition~~ and may require that the provider be appropriately licensed or certified.

R20-6-1004. Required Policy Provisions ~~and Practices: Renewability; Exclusions and Limitations; Extension of Benefits; Continuation or Conversion; Discontinuance and Replacement; Home Health Care~~

A. Renewability ~~provisions.~~

1. An individual ~~Individual~~ long-term care insurance ~~policies~~ policy shall contain a renewability provision~~. No policy issued to an individual shall contain renewal provisions other than~~ which shall be either "guaranteed renewable" or "noncancellable". ~~Such~~ The renewability provision shall be appropriately captioned, shall appear on the first page of the policy, and shall ~~clearly~~ state ~~the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed~~ that the coverage is guaranteed renewable or noncancellable. This requirement ~~shall~~ does not apply to ~~those~~ a long-term care insurance ~~policies which are~~ policy that is part of or combined with a life insurance ~~policies which do~~ policy that does not contain a renewability provision and ~~under which~~ that reserves the right not to renew ~~is reserved~~ solely to the policyholder.
2. An insurer shall not use the ~~The~~ terms "guaranteed renewable" and "noncancellable" ~~shall not be used~~ in any individual long-term care insurance policy without further explanatory language ~~in accordance with~~ according to the disclosure requirements of this Article.

3. A qualified long-term care insurance policy shall have the guaranteed renewability provisions specified in Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986 in the policy.
4. A long-term care insurance policy or certificate shall include a statement that premium rates are subject to change, unless the policy does not afford the insurer the right to raise premiums.

B. Limitations and Exclusions~~.~~

1. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, ~~such~~ the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."
2. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility ~~other than those~~ not prohibited by A.R.S. §§ ~~20-1691.02 and~~ 20-1691.03 and 20-1691.05 shall ~~set forth a description of such~~ describe the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label ~~such~~ the paragraph "Limitations or Conditions on Eligibility for Benefits."
3. ~~No~~ A policy ~~may~~ shall not be delivered or issued for delivery in this state as long-term care insurance if ~~such~~ the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:
   a. Preexisting conditions or disease;
   b. Mental or nervous disorders; however, this shall not permit exclusion or limitation of the benefits on the basis of Alzheimer's Disease;
   c. Alcoholism and drug addiction;
   d. Illness, treatment or medical condition arising out of:
      i. War, declared or undeclared, or act of war;
      ii. Participation in a felony, riot, or insurrection~~.~~**;**
      iii. Service in the armed forces or auxiliary units ~~auxiliary thereto~~;
      iv. Suicide, attempted suicide, or intentionally self-inflicted injury; or
      v. Aviation, if non-fare-paying passenger.
   e. Treatment provided in a government facility, unless otherwise required by law;
   f. ~~services~~ Services for which benefits are available under Medicare or other governmental program, except Medicaid;
   g. ~~any~~ Any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law;
   h. ~~services~~ Services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance~~.~~.
   i. Expenses for services or items available or paid under another long-term care insurance or health insurance policy; or
   j. In the case of a qualified long-term care insurance policy, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be reimbursable but for the application of a deductible or coinsurance amount;

~~f.~~4. Subsection (B)(2) ~~of this rule is not intended to~~ does not prohibit exclusions and limitations by type of provider or territorial limitations.

C. Extension of benefits~~.~~

A ~~Long-term~~ long-term care insurance ~~policies~~ policy shall provide that termination of long-term care insurance ~~shall be~~ is without prejudice to any benefits payable for institutionalization if ~~such~~ the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. An insurer may limit this ~~Such~~ extension of benefits ~~beyond the~~ period ~~the long-term care insurance was in force may be limited~~ to the duration of the benefit period, if any, or to payment of the maximum benefits~~. and may be subject to any~~ and the insurer may still apply any policy waiting period and all other applicable provisions of the policy.

D. Reinstatement

A long-term care insurance policy shall include a provision for reinstatement of coverage if a lapse occurs if the insurer receives proof that the insured was cognitively impaired or had a loss of functional capacity before expiration of the grace period in the policy. The option to reinstate shall be available to the insured for at least five months after the date of termination and shall allow for the collection of past due premiums, as appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria for these conditions set forth in the original long-term care policy.

~~**D**~~**E.** Continuation or conversion ~~provisions.~~

1. A group ~~Group~~ long-term care insurance policy ~~issued in this state on or after the effective date of this Section~~ shall provide covered individuals with a basis for continuation or conversion of coverage as specified in this subsection.
2. ~~A~~ The policy ~~providing a basis for continuation of coverage~~ shall include a ~~policy~~ provision ~~which~~ that maintains coverage under the existing group policy when ~~such~~ the coverage would otherwise terminate, ~~and which is~~ subject only to the continued timely payment of ~~premium~~ premiums when due. ~~Group policies which restrict~~ A group policy that restricts provision of benefits and services to, or ~~contain~~ has incentives to use certain providers ~~and/or~~ or facili-

ties, may provide continuation benefits ~~which~~ that are substantially equivalent to the benefits of the existing group policy. The Director shall make a determination as to the substantial equivalency of benefits and, in doing so, shall take into consideration the differences between managed care and non-managed care plans, including~~, but not limited to,~~ provider system arrangements, service availability, benefit levels and administrative complexity.

3. ~~A~~ The policy ~~providing a basis for conversion of coverage~~ shall include a ~~policy~~ provision that an individual, whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuation of the group policy in its entirety or with respect to an insured class, who has been insured under the group policy (and any group policy which it replaced), ~~shall be~~ is entitled to the issuance of a converted policy by the insurer under whose group policy ~~he or she~~ the individual is covered, without evidence of insurability.

~~a.~~4. A converted policy shall be an individual policy of long-term care insurance providing benefits identical to or benefits ~~determined by~~ that the Director determines to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers ~~and/or~~ or facilities, the Director, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans~~, including but not limited to,~~ provider system arrangements, service availability, benefit levels and administrative complexity, and other plan elements.

~~b.~~5. An insurer may require an individual seeking a conversion policy to make a written ~~Written~~ application for the converted policy ~~shall be made~~ and pay the first premium due, if any, ~~shall be paid~~ as directed by the insurer not later than 31 days after termination of coverage under the group policy. The insurer shall issue the converted policy ~~shall be issued~~ effective on the day following the termination of coverage under the group policy. The converted policy ~~and~~ shall be renewable annually.

~~c.~~6. Unless the group policy from which conversion is made replaced previous group coverage, the insurer shall calculate the premium for the converted policy ~~shall be calculated~~ on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. ~~Where~~ If the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

~~4.~~7. An insurer is required to provide continuation ~~Continuation~~ of coverage or issuance of a converted policy ~~shall be mandatory, except where~~ as provided in this subsection, unless:

a. Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

b. The terminating coverage is replaced not later than 31 days after termination, by group coverage that

i. Is effective on the day following the termination of coverage:

~~i.~~ ii. ~~Providing~~ Provides benefits identical to or benefits ~~determined by~~ the Director determines to be substantially equivalent to or in excess of those provided by the terminating coverage; and

~~ii~~ iii. ~~The~~ Has a premium ~~for which is~~ calculated in a manner consistent with the requirements of ~~paragraph (D)(3)(c) of this Section~~ subsection (E)(6).

~~5.~~8. Notwithstanding any other provision of this Section, a converted policy ~~issued~~ that an insurer issues to an individual who at the time of conversion is covered by another long-term care insurance policy ~~which provides~~ providing benefits on the basis of incurred expenses, may contain a provision ~~which results in a reduction of~~ that reduces benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100% of incurred expenses. ~~Such~~ An insurer may include this provision ~~shall only be included~~ in the converted policy only if the converted policy also provides for a premium decrease or refund ~~which~~ that reflects the reduction in payable benefits ~~payable~~.

~~6.~~9. The converted policy ~~may provide~~ that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group remained in force and effect.

~~7.~~10. Notwithstanding any other provision of this Section, any insured individual whose eligibility for group long-term care coverage is based upon ~~his or her~~ the individual's relationship to another person, ~~shall be~~ is entitled to continuation of coverage under the group policy ~~upon termination of~~ if the qualifying relationship terminates by death or dissolution of marriage.

~~E.~~**F.** Discontinuance and replacement~~.~~

If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

1. Shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and
2. Shall not vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services.

G. Premium Increases

1. An insurer shall not increase the premium charged to an insured because of:
   a. The insured aging beyond age 65; or
   b. The duration of coverage under the policy.
2. Purchase of additional coverage is not considered a premium rate increase, however, for the calculation required under R20-6-1019, an insurer shall add to and consider the portion of the premium attributable to the additional coverage as part of the initial annual premium.
3. A reduction in benefits is not considered a premium change, however, for the calculation required under R20-6-1019, an insurer shall base the initial annual premium on the reduced benefits.

H. Electronic enrollment for group policies
1. For coverage offered to a group defined in A.R.S. § 20-1691(5)(a), any requirement that an insurer or insurance producer obtain an insured's signature is satisfied if:
   a. The group policyholder or insurer obtains the insured's consent by telephonic or electronic enrollment, and provides the enrollee with verification of enrollment information within five business days of enrollment; and
   b. The telephonic or electronic enrollment process has safeguards to assure the accuracy, retention, and prompt retrieval of records, and the confidentiality of personal and privileged information.
2. If the Director requests, the insurer shall make available records showing the insurer's ability to confirm enrollment and coverage amounts.

~~F~~**I.** Minimum standards for home health care benefits
1. ~~A~~ If an insurer issues a long-term care insurance policy or certificate ~~may not, if it~~ that provides benefits for home-health ~~services~~ care, the policy or certificate shall not limit or exclude benefits by any of the following:
   a. ~~By requiring~~ Requiring that the insured~~/claimant~~ would need skilled care in a skilled nursing facility if home health services ~~were~~ are not provided;
   b. ~~By requiring~~ Requiring that the insured~~/claimant~~ first or simultaneously receive nursing ~~and/or~~ or therapeutic services in a home or community setting before home health services are covered;
   c. ~~By limiting~~ Requiring that eligible services ~~to services~~ be provided by a registered ~~nurses~~ nurse or licensed practical ~~nurses~~ nurse;
   d. ~~By requiring~~ Requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide or other licensed or certified home care worker acting within the scope of ~~his or her~~ licensure or certification~~.~~ ;
   e. ~~By requiring~~ Requiring that the insured~~/claimant~~ have an acute condition before home health services are covered;
   f. ~~By limiting~~ Limiting benefits to services provided by Medicare-certified agencies or providers~~.~~ ;
   g. Excluding coverage for personal care services provided by a home health aide;
   h. Requiring that home health care services be provided at a level of certification or licensure greater than that required by the eligible service; or
   i. Excluding coverage for adult day care services.
2. An insurer may apply home ~~Home~~ health care coverage ~~may be applied~~ to ~~the~~ non-home health care benefits ~~provided~~ in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

J. Appeals. Policy shall include a clear description of the process for appealing and resolving benefit determinations.

R20-6-1005. Unintentional Lapse

A. An insured may designate in writing at least one person to receive notice of lapse and termination of a long-term care insurance policy for nonpayment of premium, in addition to the insured. Designation shall not constitute acceptance of any liability by the third-party notice recipient for services provided to the insured.

B. An insurer shall not issue a long-term care insurance policy until the applicant has provided either a written designation of at least one person in addition to the applicant, who shall receive notice of lapse or termination, with the person's full name and home address, or the applicant's written waiver, dated and signed, indicating that the applicant chooses not to designate a notice recipient.

C. The insurer shall use a form for written designation or waiver that provides space clearly delineated for the designation. The insurer shall include the following language on the form for waiver of the right to name a designated recipient: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that this notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."

D. At least once every two years, an insurer shall notify the insured of the right to change the person designated to receive notice in subsection (A). An insured may add, delete, or change a designated recipient or change a designated recipient at any time by notifying the insurer in writing, and providing the name and home address for the new designated recipient or the designated recipient to be deleted.

E. If the insured pays premiums for the long-term care insurance policy through a payroll or pension deduction plan, the insurer is not required to comply with the requirements in subsections (A) through (D) until 60 days after the insured is no

longer on the payment plan.

F. An individual long-term care insurance policy shall not lapse or be terminated for nonpayment of premium unless the insurer gives the insured and any recipient designated under subsections (A) through (D) written notice at least 30 days before the effective date of termination or lapse, by first class mail, postage prepaid. An insurer shall not give notice until 30 days after the date on which a premium is due and unpaid. Notice is deemed given five days after the date of mailing.

~~R20-6-1005.~~R20-6-1006. Inflation Protection

A. ~~No~~ An insurer ~~may~~ shall not offer a long-term care insurance policy unless the insurer offers, at the time of purchase, in addition to any other inflation protection, the option to purchase a policy with an inflation protection provision to address the reduction or limitation on the value of benefits that may result from inflation over time. The terms of ~~such~~ the required provision shall be no less favorable than the following:

1. A ~~term~~ provision ~~providing~~ that provides for increases in benefit levels compounding annually at a rate of no less than 5%;
2. A ~~term providing for guaranteed periodic increases in~~ provision that allows an insured to periodically increase benefit levels without ~~requiring~~ providing evidence of insurability or health status, ~~provided~~ if the insured did not decline the option for the previous period ~~had not been declined~~. The increased benefit shall be no less than the difference between the existing benefit and that benefit compounded annually at a rate of no less than 5% from the purchase of the existing benefit until the year in which the offer is made; or
3. A ~~term providing for~~ provision for coverage of a specified percentage of actual or reasonable charges that is not ~~limited~~ subject to a maximum indemnity amount or limit.

B. ~~Where~~ If the policy is issued to a group, the insurer shall extend the offer required ~~offer in~~ by subsection (A) ~~shall be made~~ to the group policyholder; except, if the policy is issued under A.R.S. § 20-1691.04(C) to a group ~~authorized by A.R.S. § 20-1691.02(D),~~ other than to a continuing care retirement community, the insurer shall make the offer ~~offering shall be made~~ to each proposed certificateholder.

C. ~~The~~ An insurer is not required to make the offer in subsection (A) ~~shall not be required of~~ for life insurance policies or riders ~~containing~~ with accelerated long-term care benefits.

D. ~~Insurers~~ An insurer shall include the ~~following~~ information listed in this subsection in or with the outline of coverage~~:~~.

1. A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period.
2. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall ~~also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75 and 85 for benefit increases~~ provide a revised schedule of attained-age premiums. An insurer may use a hypothetical or a graphic demonstration for ~~the purposes of~~ this disclosure.

E. Inflation-protection benefit increases shall continue without regard to an insured's age, claim status, claim history, or length of time insured under the policy.

F. An insurer's offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium that the insurer expects to remain constant. The insurer shall disclose in the offer in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

G. An insurer shall include in a long-term care insurance policy inflation protection as provided in subsection (A)(1) unless an insurer obtains a rejection of inflation protection signed by the insured as required in subsection (H). The rejection may be either on the application form or on a separate form.

H. A rejection of inflation protection is deemed part of an application and shall state: "I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I reviewed Plans [insert description of plans], and I reject inflation protection."

~~R20-6-1006.~~R20-6-1007. Required Disclosure Provisions

A. Riders and endorsements. Except for riders or endorsements by which ~~the~~ an insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, ~~all riders~~. if an insurer adds a rider or ~~endorsements~~ endorsement ~~added~~ to an individual long-term care insurance policy after date of issue or at reinstatement or renewal ~~which~~ that ~~reduce~~ reduces or ~~eliminate~~ eliminates benefits or coverage in the policy, the insurer shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement ~~which~~ that increases benefits or coverage with a concomitant increase in premium during the policy term ~~must be agreed to in writing~~ shall require the signed written agreement of ~~by~~ the insured~~, except if~~ unless the increased benefits or coverage are required by law. ~~Where~~ If the insurer charges a separate additional premium ~~is charged~~ for benefits provided in connection with riders or endorsements, ~~such~~ the premium charge shall be set forth in the policy, rider, or endorsement.

B. Payment of Benefits. A long-term care insurance policy ~~which~~ that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall ~~include a definition of such~~ define the terms and ~~an explanation of such terms~~ explain them in its accompanying outline of coverage.

C. Disclosure of tax consequences. ~~With regard to~~ For life insurance policies ~~which~~ that provide an accelerated benefit for

long-term care, an insurer shall provide a disclosure statement ~~is required~~ at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted, that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax adviser. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents.

D. Benefit triggers. A long-term care insurance policy shall use activities of daily living and cognitive impairment to measure an insured's need for long-term care. The long-term care insurance policy or certificate shall describe these terms and provisions in a separate paragraph in the policy or certificate labeled "Eligibility for the Payment of Benefits" that includes and explains:

1. Any additional benefit triggers;
2. Benefit triggers that result in payment of different benefit levels;
3. Any requirement that an attending physician or other specified person certify a certain level of functional dependency for the insured to be eligible for benefits.

E. A long-term care insurance policy or certificate shall contain a disclosure statement in the policy and in the outline of coverage indicating whether it is intended to be a qualified long-term care insurance contract as specified in the outline of coverage in Appendix J, paragraph 3.

R20-6-1008. Required Disclosure of Rating Practices to Consumers

A. This Section applies as follows:

1. Except as provided in subsection (A)(2), this Section applies to any long-term care policy or certificate issued in this state on or after May 10, 2005.
2. For certificates issued under an in-force, long-term care insurance policy issued to a group as defined in A.R.S. § 20-1691(5)(a), the provisions of this Section apply on the first policy anniversary that occurs on or after November 10, 2005.

B. Unless a policy is one for which an insurer can not increase the applicable premium rate or rate schedule, the insurer shall provide the information listed in this subsection to the applicant at the time of application or enrollment. If the method of application does not allow for delivery at that time, the insurer shall provide the information to the applicant no later than at the time of delivery of the policy or certificate.

1. A statement that the policy may be subject to rate increases in the future.
2. An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option if a premium rate revision occurs.
3. The premium rate or rate schedules applicable to the applicant that will be in effect until the insurer makes a request for an increase.
4. A general explanation for applying premium rate or rate schedule adjustments that includes:
   a. A description of when premium rate or rate-schedule adjustments will be effective (e.g., next anniversary date, next billing date); and
   b. The insurer's right to a revised premium rate or rate schedule as provided in subsection (B)(3) if the premium rate or rate schedule is changed.
5. Information regarding each premium rate increase on this policy form or similar policy form over the past 10 years for this state or any other state, that, at a minimum, identifies:
   a. The policy forms for which premium rates have been increased;
   b. The calendar years when the form was available for purchase; and
   c. The amount or percent of each increase, which may be expressed as a percentage of the premium rate before the increase, or as minimum and maximum percentages if the rate increase is variable by rating characteristics.
6. The insurer may, in a fair manner, provide explanatory information related to the rate increases in addition to the information required under subsection (B)(5).

C. An insurer may exclude from the disclosure required under subsection (B)(5), premium rate increases applicable to:

1. Blocks of business acquired from other nonaffiliated insurers; and
2. Policies acquired from other nonaffiliated insurers if the increases occurred before the acquisition.

D. If an acquiring insurer files for a rate increase on a long-term care insurance policy form or a block of policy forms acquired from a nonaffiliated insurer on or before the later of the January 10, 2005 or the end of a twenty-four-month period following the acquisition of the policies or block of policies, the acquiring insurer may exclude that rate increase from the disclosure required under subsection (B)(5). However, the nonaffiliated insurer that sells the policy form or a block of policy forms shall include that rate increase in the disclosure required under subsection(B)(5). If the acquiring insurer files for a subsequent rate increase, even within the twenty-four-month period, on the same policy form acquired from a nonaffiliated insurer or block of policy forms acquired from nonaffiliated insurers, the acquiring insurer shall make all disclosures required by subsection (B)(5), including disclosure of the earlier rate increase.

E. Unless the method of application does not allow an insured to sign an acknowledgement that the insurer made the disclosures required under subsection (B) at the time of application, the applicant shall sign an acknowledgement of disclosure at that time. Otherwise, the applicant shall sign a disclosure acknowledgement no later than at the time of delivery of the policy or certificate.

F. An insurer shall use the forms in Appendix A and Appendix B to comply with the requirements of subsections (B) through (E). The text and format of an insurer's forms shall be substantially similar to the text and format of Appendices A and B.

G. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least 45 days before the effective date of the increase. The notice shall include the information required by subsection (B).

R20-6-1009. Initial Filing Requirements

A. This Section applies to any long-term care policy issued in this state on or after May 10, 2005.

B. At the time of making a filing under A.R.S. § 20-1691.08, an insurer shall provide the Director a copy of the disclosure documents required under R20-6-1008 and an actuarial certification that includes the following:

1. The initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;
2. The policy design and coverage provided have been reviewed and taken into consideration;
3. The underwriting and claims adjudication processes have been reviewed and taken into consideration;
4. A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:
   a. Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;
   b. A statement that the assumptions used for reserves contain reasonable margins for adverse experience;
   c. A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and
   d. A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur;
      i. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;
      ii. If the gross premiums for certain age groups appear to be inconsistent with this requirement, the Director may request a demonstration under subsection (C) based on a standard age distribution; and.
5. A statement that the premium rate schedule:
   a. Is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or
   b. A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

C. The Director may require an insurer to provide an actuarial demonstration that benefits provided under a long-term care policy are reasonable in relation to premiums charged. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

~~**R20-6-1007.**~~**R20-6-1010. Requirements for Application Forms and Replacement Coverage**

A. An insurer's application form for a long-term care insurance policy ~~Application forms~~ shall include the ~~following~~ questions listed in this Section ~~designed~~ to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other ~~accident and sickness~~ health or long-term care policy or certificate presently in force. An insurer may include the questions in a ~~A~~ supplementary application or other form to be signed by the applicant and ~~agent~~ insurance producer, except where the coverage is sold without ~~an agent~~ an insurance producer~~, containing such questions may be used~~. ~~With regard to~~ For a replacement policy issued to a group as defined ~~by~~ in A.R.S. § ~~20-1691(4)(a)(i)~~ 20-1691(5)(a), the insurer may modify the ~~following~~ questions ~~may be modified~~ only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced~~; provided, however, that~~ if the certificate holder has been notified of the replacement.

1. Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?
2. Did you have another long-term care insurance policy or certificate in force during the last 12 months?
   a. If so, with which company?
   b. If that policy lapsed, when did it lapse?
3. Are you covered by Medicaid?
4. Do you intend to replace any of your medical or health insurance coverage with this policy or ~~[~~certificate~~]~~?

B. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan the applicant selects.

~~**B.**~~**C.** ~~Agents~~ An insurance producer shall list any other health insurance policies ~~they have~~ the insurance producer has sold to

the applicant, including:~~.~~
1. ~~List policies sold which~~ Policies that are still in force.
2. ~~List policies~~ Policies sold in the past 5 years ~~which~~ that are no longer in force.

~~C.~~**D.** ~~Solicitations other than direct response. Upon~~ On determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its ~~agent~~ insurance producer shall furnish the applicant, ~~prior to issuance or delivery~~ before issuing or delivering of the individual long-term care insurance policy, a notice that substantially conforms to the form prescribed in Appendix C regarding replacement of ~~accident and sickness~~ health or long-term care coverage. ~~One~~ The insurer shall:
1. Give one copy of ~~such~~ the notice ~~shall be retained by~~ to the applicant; and
2. Keep an additional copy signed by the applicant ~~shall be retained by the insurer~~. ~~The required notice shall be in the form prescribed in Appendix A.~~

~~D.~~**E.** ~~Direct response solicitations.~~ Insurers using direct response solicitation methods shall deliver a notice regarding replacement of ~~accident and sickness~~ health or long-term care coverage to the applicant upon issuance of the policy. ~~The required notice shall be in the form prescribed in Appendix B.~~

~~E.~~**F.** ~~Where~~ If replacement is intended, the replacing insurer shall ~~notify, in writing,~~ send the existing insurer written notice of the proposed replacement within five working days from the date the replacing insurer receives the application or issues the policy, whichever is sooner. The notice shall identify the existing policy ~~shall be identified~~ by name of the insurer~~, name of~~ and the insured, and policy number or insured's address including zip code. ~~Such notice shall be made within 5 working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.~~

G. A life insurance policy that accelerate benefits for long-term care shall comply with this Section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of Title 20, Chapter 6, Article 1.1. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with the requirements of this Section and with Title 20, Chapter 6, Article 1.1.

~~F.~~**H.** If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits ~~to the extent that~~ if similar exclusions ~~have been~~ are satisfied under the original policy.

~~G.~~**I.** Reporting requirements~~.~~
1. ~~Every~~ An insurer shall maintain the following records for each ~~agent~~ insurance producer: ~~of that agent's~~
   a. The amount of the insurance producer's replacement sales as a percent of the ~~agent's~~ insurance producer's total annual sales; and
   b. The ~~the~~ amount of lapses of long-term care insurance policies sold by the ~~agent~~ insurance producer as a percent of the ~~agent's~~ insurance producer's total annual sales.
2. ~~Each~~ No later than June 30 of each year, on the forms specified in Appendix E and Appendix F, an insurer shall report the following information for the preceding calendar year to the Department: ~~annually by June 30~~
   a. The ~~the~~ 10% of its ~~agents~~ insurance producers licensed in Arizona with the greatest percentages of lapses and replacements as measured by ~~paragraph~~ subsection (H)(1) ~~of this subsection~~; and~~.~~
3. ~~Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.~~
   ~~4.~~b. ~~Every insurer shall report annually by June 30 the~~ The number of lapsed policies as a percent of ~~it's~~ the insurer's total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.
   ~~5.~~c. ~~Every insurer shall report annually by June 30 the~~ The number of replacement policies sold as a percent of ~~it's~~ the insurer's total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year; and~~.~~
   d. For qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied.

~~6.~~**J.** ~~For purposes of this Section~~ In subsection (I),
1. "Claim" means a request for payment of benefits under an in-force policy, regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;
2. "Denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition;
3. ~~"policy" shall mean~~ "Policy" means only long-term care insurance; and
4. ~~"report"~~ "Report" means on a statewide basis.

~~R20-6-1008.~~R20-6-1011. Prohibition Against Post-claims Underwriting

A. ~~All applications~~ An application for a long-term care insurance ~~policies or certificates except those which are~~ policy or certificate that is not guaranteed issue shall meet the requirements of this Section.
1. The application shall contain ~~contain~~ clear and unambiguous questions designed to ascertain the applicant's health

condition ~~of the applicant~~.

~~1.~~a. If ~~an~~ the application ~~for long-term care insurance contains~~ has a question ~~which asks~~ asking whether the applicant has had medication prescribed by a physician, ~~it must~~ the application shall also ask the applicant to list the prescribed medication ~~that has been prescribed~~.

~~2.~~b. If the insurer knew or reasonably should have known that the medications listed in ~~such~~ the application ~~were known by the insurer, or should have been known at the time of application, to be directly~~ are related to a medical condition for which coverage would otherwise be denied, ~~then~~ the insurer shall not rescind the policy or certificate ~~shall not be rescinded~~ for that condition.

~~**B.** Except for policies or certificates which are guaranteed issue:~~

~~1.~~2. The application shall include the following language which shall be set out conspicuously and in close conjunction with the applicant's signature block ~~on an application for a long-term care insurance policy or certificate~~: "Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy."

~~2.~~3. The policy or certificate shall contain the following language, or language substantially similar to the following, ~~shall be~~ set out conspicuously ~~on the long-term care insurance policy or certificate at the time of delivery~~: "Caution: The issuance of this long-term care insurance [policy] [certificate] is based ~~upon~~ on your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! ~~if~~ If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]."

~~3.~~**B.** ~~Prior to issuance of~~ Before issuing a long-term care insurance policy or certificate that is not guaranteed issue to an applicant age 80 or older, the insurer shall obtain ~~1~~ one of the following:

a. A report of a physical examination;
b. An assessment of functional capacity;
c. An attending physician's statement; or
d. Copies of medical records.

C. ~~A~~ The insurer or it's insurance producer shall deliver a copy of the completed application or enrollment form, ~~(whichever is~~ as applicable~~)~~ ~~shall be delivered~~ to the insured no later than at the time of delivery of the policy or certificate unless the insurer gave a copy to the applicant it ~~was retained by the applicant~~ at the time of application.

D. ~~Every~~ An insurer ~~or other entity~~ selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state- and ~~countrywide~~ country-wide, except those which the insured voluntarily effectuated.

E. On or before March 31 of each year, ~~insurers~~ an insurer shall report the following information to the Director for the ~~prior~~ preceding calendar year, using the form prescribed in Appendix G:

1. ~~Company~~ Insurer name, address, phone number;
2. As to each rescission except those voluntarily effectuated by the insured:
   a. Policy form number;
   b. Policy and certificate number;
   c. Name of the insured;
   d. Date of policy issuance;
   e. ~~Date(s) claim(s)~~ Date claim submitted;
   f. Date of rescission; and
   g. Detailed reason for rescission.
3. Signature, name and title of the preparer, and date prepared.

~~R20-6-1009.~~R20-6-1012. Discretionary Powers of Director

The Director may, ~~upon~~ on written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provision of this Article with respect to a specific long-term care insurance policy or certificate upon a written finding that:

1. The modification or suspension would be in the best interest of the insureds; and
2. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and
   a. The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or
   b. The policy or certificate is to be issued to residents of a life-care or continuing-care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or
   c. The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

~~R20-6-1010.~~R20-6-1013. Reserve Standards

A. ~~When~~ If long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders ~~to such policies~~, an insurer shall determine policy reserves for ~~such~~ long-term care benefits ~~shall be~~ are determined ~~in accordance with~~ under A.R.S. § 20-510. An insurer shall establish ~~Claim~~ claim reserves shall ~~also~~ be established ~~in the case when such~~ for a policy or rider ~~is~~ in claim status.

B. An insurer shall base reserves ~~Reserves~~ for policies and riders ~~subject to this~~ under subsection (A) ~~may be based~~ on the multiple decrement model ~~utilizing~~ using all relevant decrements except for voluntary termination rates. An insurer may use single ~~Single~~ decrement approximations ~~may be acceptable~~ if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The insurer, when calculating reserves, ~~calculations~~ may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. ~~However, in no event shall~~ The insurer shall not set the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

C. In the development and calculation of reserves for policies and riders subject to this ~~subsection~~ Section, an insurer shall give due regard ~~shall be given~~ to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which ~~have an~~ impact ~~on~~ projected claim costs including~~, but not limited to,~~ the following:

1. Definition of insured events;
2. Covered long-term care facilities;
3. Existence of home convalescence care coverage;
4. Definition of facilities;
5. Existence or absence of barriers to eligibility;
6. Premium waiver provision;
7. Renewability;
8. Ability to raise premiums;
9. Marketing method;
10. Underwriting procedures;
11. Claims adjustment procedures;
12. Waiting period;
13. Maximum benefit;
14. Availability of eligible facilities;
15. Margins in claim costs;
16. Optional nature of benefit;
17. Delay in eligibility for benefit;
18. Inflation protection provisions; ~~and~~
19. Guaranteed insurability option~~.~~; and
20. Other similar or comparable factors affecting risk.

D. A member of the American Academy of Actuaries shall certify an insurer's use of any ~~Any~~ applicable valuation morbidity table ~~shall be certified~~ as appropriate as a statutory valuation table ~~by a member of the American Academy of Actuaries~~.

E. When long-term care benefits are provided other than as described in subsection (A), an insurer shall determine reserves ~~shall be determined in accordance with~~ under A.R.S. § 20-508.

~~R20-6-1014. Filing Requirements for Advertising~~

~~Every insurer, health care service organization or other entity providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio or television medium to the Director for review and approval by the Director pursuant to A.R.S. § 20-1110(E). In addition, all advertisements shall be retained by the insurer, health care service organization or other entity for at least 3 years from the date the advertisement was first used.~~

~~R20-6-1011.~~R20-6-1014. Loss ~~ratio~~ Ratio

A. This Section applies to policies and certificates issued any time prior to May 10, 2005.

B. Benefits under an individual long-term care insurance ~~policies shall be~~ policy is deemed reasonable in relation to premiums if ~~provided~~ the expected loss ratio is at least 60% calculated in a manner ~~which~~ that provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, ~~due consideration shall be given~~ the director shall consider to all relevant factors, including:

1. Statistical credibility of incurred claims experience and earned premiums;
2. The period for which rates are computed to provide coverage;
3. Experienced and projected trends;
4. Concentration of experience within early policy duration;
5. Expected claim fluctuation;
6. Experience refunds, adjustments, or dividends;
7. Renewability features;
8. All appropriate expense factors;

9. Interest;
10. Experimental nature of the coverage;
11. Policy reserves;
12. Mix of business by risk classification; and
13. Product features such as long elimination periods, high deductibles, and high maximum limits.

C. Subsection (B) does not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is deemed to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following:

1. The interest credited internally to determine cash value accumulations, including long-term care, if any, is guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy.
2. The portion of the policy that provides life insurance benefits complies with the nonforfeiture requirements of A.R.S. § 20-1231;
3. The policy complies with the disclosure requirements of A.R.S. § 20-1691.06(A) through (E);
4. At the time of making a filing under A.R.S. § 20-1691.08, the insurer files an actuarial memorandum that includes the following information:
   a. A description of the basis on which the long-term care rates were determined;
   b. A description of the basis for the reserves;
   c. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
   d. A description and a table of each actuarial assumption used; for expenses, an insurer shall include percent of premium dollars per policy and dollars per unit of benefits, if any;
   e. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
   f. The estimated average annual premium per policy and the average issue age;
   g. A statement as to whether underwriting is performed, including:
      i. Time of underwriting;
      ii. A description of the type of underwriting used, such as medical underwriting or functional assessment underwriting; and
      iii. For a group policy, whether an enrollee's dependents are subject to underwriting; and
   h. A description of the effect of the long-term care policy provisions on the required premiums, nonforfeiture values, and reserves on the underlying life insurance policy, both for active lives and those in long-term care status.

R20-6-1015. Premium Rate Schedule Increase

A. In this Section, "exceptional increase" means a rate increase that an insurer has filed and that the Director has determined is justified because of changes in laws applicable to long-term care insurance, or increased and unexpected utilization that affects the majority of insurers of similar products. The Director may request independent actuarial review on the issue of whether an increase should be deemed an exceptional increase. The Director may also determine whether there are any potential offsets to higher claims costs.

B. This Section applies to any individual long-term care policy or certificate issued in this state on or after May 10, 2005.

C. An insurer shall notify the Director of a proposed premium rate schedule increase, including an exceptional increase, at least 30 days before issuing notice to its policyholders. The notice to the Director shall include:

1. Information required by R20-6-1008;
2. Certification by a qualified actuary that:
   a. If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;
   b. The premium rate filing complies with the provisions of this Section;
3. An actuarial memorandum justifying the rate schedule change request that includes:
   a. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase and the method and assumptions used in determining the projected values, including the following:
      i. Any assumptions that deviate from those used for pricing other forms currently available for sale;
      ii. Annual values for the five years preceding and the three years following the valuation date, provided separately,
      iii. Development of the lifetime loss ratio, unless the rate increase is an exceptional increase;
      iv. A demonstration of compliance with subsection (D); and
   b. For exceptional increases, the actuarial memorandum shall also include:
      i. The projected experience that is limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and
      ii. If the Director determines under subsection (A) that offsets may exist, the insurer shall use appropriate net projected experience;

c. Disclosure of how reserves have been incorporated in this rate increase when the rate increase will trigger contingent benefit upon lapse;
d. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and any other actions of the insurer on which the actuary has relied;
e. A statement that the actuary has considered policy design, underwriting, and claims adjudication practices; and

4. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless the insurer provides the Director with documentation justifying the greater rate; and
5. Upon the Director's request, other similar and related information the Director may require to evaluate the premium rate schedule increase.

D. The following requirements apply to all premium rate schedule increases:
1. The insurer shall return 70% of the present value of projected additional premiums from an exceptional increase to policyholders in benefits;
2. The sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, shall not be less than the sum of the following:
   a. The accumulated value of the initial earned premium times 58%;
   b. 85% of the accumulated value of prior premium rate schedule increases on an earned basis;
   c. The present value of future projected initial earned premiums times 58%; and
   d. 85% of the present value of future projected premiums not in subsection(D)(2)(c) on an earned basis;
3. If a policy form has both exceptional and other increases, the values in subsection (D)(2)(b) and (D)(2)(d) shall also include 70% for exceptional rate increase amounts; and
4. All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in the NAIC Accounting Practices and Procedures Manual to which insurers are subject under A.R.S. § 20-223. The actuary shall disclose the use of any appropriate averages in the actuarial memorandum required under subsection (B)(3).

E. For each rate increase that is implemented, the insurer shall file for approval by the Director updated projections, as defined in subsection (C)(3)(a), annually for the next three years and shall include a comparison of actual results to projected values. The Director may extend the reporting period beyond three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subsection (K), the insurer shall provide the projections required by this subsection to the policyholder instead of filing with the Director.

F. If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, the insurer shall file lifetime projections, as defined in subsection (C)(3)(a), for the Director's approval every five years following the end of the required period in subsection (E). For group insurance policies that meet the conditions in subsection (L), the insurer shall provide the projections required by this subsection to the policyholder instead of filing with the Director.

G. If the Director finds that the actual experience following a rate increase does not match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection (D), the Director may require the insurer to implement premium rate schedule adjustments or other measures to reduce the difference between the projected and actual experience. In determining whether the actual experience matches the projected experience, the Director shall consider subsection (C)(3)(e), if applicable.

H. If the majority of the policies to which the increase applies are eligible for the contingent benefit upon lapse, the insurer shall file:
1. A plan, subject to Director approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form experience requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the Director may impose the condition in subsections (I) through (K); and
2. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subsection (D) had the greater of the original anticipated lifetime loss ratio or 58% has been used in the calculations described in subsection (D)(2)(a) and (D)(2)(c).

I. For a rate increase filing that meets the criteria listed in this subsection, the Director shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if lapsation in excess of projected lapsation has occurred or is anticipated:
1. The rate increase is not the first rate increase requested for the specific policy form or forms;
2. The rate increase is not an exceptional increase; and
3. The majority of the policies or certificates to which the increase applies are eligible for the contingent benefit upon lapse.

J. If the Director finds excess lapsation under subsection (I), the Director may find that a rate spiral exists and may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase, the option to replace existing

coverage with one or more comparable products offered by the insurer or its affiliates. The terms of the offer and the information communicating the offer are subject to the Director's approval. The offer shall:

1. Be based on actuarially sound principles, but not on attained age; and
2. Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy; and
3. Allow the insured the option of retaining the existing coverage.

K. The insurer shall maintain the experience of the insureds whose coverage was replaced under subsection (J) separate from the experience of insureds originally issued the policy forms. If the insurer requests a rate increase on the policy form, the rate increase shall be limited to the lesser of:

1. The maximum rate increase determined based on the combined experience; and
2. The maximum rate increase determined based only on the experience of the insureds originally issued the form, plus ten percent.

L. If the Director finds that an insurer has exhibited a history or pattern of filing inadequate initial premium rates for long-term care insurance, after considering the total number of policies filed over a period of time and the percentage of policies with inadequate rates, the Director may, in addition to remedies available under subsections (I) through (K), prohibit the insurer from the following:

1. Filing and marketing comparable coverage for a period of up to five years; and
2. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

M. Subsections (B) through (L) shall not apply to a policy for which long-term care benefits provided by the policy are incidental, as provided under subsection (A), if the policy complies with all of the following provisions:

1. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
2. The portion of the policy that provides insurance benefits other than long-term care coverage meets the applicable nonforfeiture requirements under state law, including A.R.S. §§ 20-1231, 20-1232 and 20-2636;
3. The policy meets the disclosure requirements of A.R.S. § 20-1691.06;
4. The portion of the policy that provides insurance benefits other than long-term care coverage meets the disclosure requirements as applicable in the following:
   a. Title 20, Chapter 6, Article 1.2; and
   b. Title 20, Chapter 16, Article 2.
5. At the time of making a filing under A.R.S. § 20-1691.08, the insurer files an actuarial memorandum that includes:
   a. Description of the bases on which the actuary determined the long-term care rates and the reserves;
   b. A summary of the type of policy, benefits, renewability provisions, general marketing method, and limits on ages of issuance;
   c. A description and a table of each actuarial assumption used, with the percent of premium dollars per policy and dollars per unit of benefits, if any, for expenses;
   d. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
   e. The estimated average annual premium per policy and the average issue age;
   f. A statement as to whether the insurer performs underwriting at the time of application with an explanation of the following:
      i. Whether underwriting is used, and, if used, a description of the type of underwriting, such as medical underwriting or functional assessment underwriting; and
      ii. For a group policy, whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
   g. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

~~R20-6-1012.~~R20-6-1016. Filing ~~Requirement~~ Requirements for Group ~~Policy~~ Policies ~~Issued in Another State~~

A. Out-of-State Policies. ~~Prior to~~ Before an insurer or similar organization ~~offering~~ may offer group long-term care insurance to a resident of this state ~~pursuant to~~ under A.R.S. § 20-1691.02(D), ~~it~~ the insurer or organization shall file with the Director evidence that ~~the group policy or certificate thereunder has been approved by~~ a state ~~having~~ with statutory or regulatory long-term care insurance requirements substantially similar to those ~~adopted in~~ of this state has approved the group policy or certificate for use in that state.

B. Associations. For long-term policies marketed or issued to associations, the insurer or organization shall file with the insurance department the policy, certificate, and corresponding outline of coverage.

~~R20-6-1013.~~R20-6-1017. Standards for Marketing

A. Every insurer~~, health care service organization or other entity~~ marketing long-term care insurance coverage in this state, directly or through ~~its producers~~ an insurance producer shall:

1. Establish marketing procedures to assure that any comparison of policies by its ~~agents or other~~ insurance producers ~~will be~~ is fair and accurate, and ~~to assure~~ that excessive insurance is not sold or issued.
2. Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy, the following language: "Notice ~~of~~ to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."
3. Provide the applicant with copies of the disclosure forms in Appendices A and B.

~~3.~~4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has ~~accident and sickness~~ health or long-term care insurance and the types and amounts of any such insurance.

5. Provide an explanation of contingent benefit upon lapse as provided for in R20-6-1019(E).
6. Provide written notice to an applicant or prospective policyholder or certificateholder advising of this state's senior insurance counseling program (SHIP), and the name, address, and phone number for the SHIP, at the time of solicitation.

~~B.~~7. ~~Every insurer or entity marketing long-term care insurance shall establish~~ Establish auditable procedures for verifying compliance with this ~~subsection~~ Section.

~~C.~~B. In addition to the practices prohibited in A.R.S. § 20-441 et seq., the following acts and practices are prohibited:

1. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or ~~convent~~ convert any insurance policy or to take out a policy of insurance with another insurer.
2. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.
3. Cold lead advertising. Making use directly or indirectly or any method of marketing ~~which~~ that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance ~~agent~~ insurance producer or insurance company.
4. Misrepresentation. Misrepresenting a fact in selling or offering to sell a long-term care insurance policy.

C. An insurer shall not market or issue a long-term care policy or certificate to an association unless the insurer files the information required under R20-6-1016(B) and annually certifies that the association has complied with the requirements of this Section.

~~D.~~ ~~Appropriateness of recommended purchase. In recommending the purchase of or replacement of any long-term care insurance policy or certificate, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.~~

R20-6-1018. Suitability

A. This Section does not apply to life insurance policies that accelerate benefits for long-term care.

B. Every insurer or other person marketing long-term care insurance, including an insurance producer or managing general agent, (the "issuer") shall:

1. Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;
2. Train its insurance producers in the use of its suitability standards; and
3. Maintain a copy of its suitability standards and make them available for inspection upon the Director's request.

C. To determine whether an applicant meets an issuer's suitability standards, the insurance producer and issuer shall develop procedures that take the following into consideration:

1. The applicant's ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;
2. The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and
3. The values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.

D. The issuer shall make reasonable efforts to obtain the information set out in subsection (C)(1), including giving the applicant the "Long-Term Care Insurance Personal Worksheet" prescribed in Appendix A, to complete before or at the time of application. The issuer shall use a personal worksheet that contains, at a minimum, the information contained in Appendix A, in substantially the same text and format, in not less than 12 point type. The issuer may ask the applicant to provide additional information to comply with its suitability standards. An issuer shall file a copy of its personal worksheet with the Director.

E. An issuer shall not consider an applicant for coverage until the issuer has received the applicant's completed personal worksheet, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.
F. No one shall sell or disseminate information obtained through the personal worksheet outside the issuer that obtains the worksheet.
G. The issuer shall use its suitability standards to determine whether issuance of long-term care insurance coverage to a particular applicant is appropriate.
H. An insurance producer shall use the suitability standards developed by the issuer in marketing long-term care insurance.
I. When giving an applicant a personal worksheet, the issuer shall also provide the applicant with a disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance." The form shall be in substantially the same format and text contained in Appendix H, in not less than 12 point type.
J. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter that is substantially similar to Appendix I. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent to purchase the long-term care policy. The issuer shall have either the applicant's returned Appendix I letter or a record of the alternative method of verification as part of the applicant's file.
K. The issuer shall report annually to the Director the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter as prescribed in subsection (J).

R20-6-1019. Nonforfeiture Benefit Requirement
A. This Section does not apply to life insurance policies or riders containing accelerated long-term care benefits.
B. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of A.R.S. § 20-1691.11, an insurer shall meet the following requirements:
1. A policy or certificate offered with nonforfeiture benefits shall have the same coverage elements, eligibility, benefit triggers and benefit length as a policy or certificate issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subsection (I).
2. The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.

C. If the offer required to be made under A.R.S. § 20-1691.11 is rejected, the insurer shall provide the contingent benefit upon lapse described in this Section.
D. If a prospective policyholder rejects the offer of a nonforfeiture benefit, the insurer shall provide the contingent benefit upon lapse described in this Section for individual and group policies without the nonforfeiture benefit, issued after January 10, 2005.
E. If a group policyholder elects to make the nonforfeiture benefit an option to a certificateholder, the certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.
F. The contingent benefit on lapse is triggered when:
1. An insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in the chart below, based on the insured's issue age; and
2. The policy or certificate lapses within 120 days of the due date of the increased premium.

Triggers for a Substantial Premium Increase		
Issue Age		Percent Increase Over Initial Premium
29 and under		200%
30-34		190%
35-39		170%
40-44		150%
45-49		130%
50-54		110%
55-59		90%
60		70%
61		66%

62		62%
63		58%
64		54%
65		50%
66		48%
67		46%
68		44%
69		42%
70		40%
71		38%
72		36%
73		34%
74		32%
75		30%
76		28%
77		26%
78		24%
79		22%
80		20%
81		19%
82		18%
83		17%
84		16%
85		15%
86		14%
87		13%
88		12%
89		11%
90 and over		10%

G. Unless otherwise required, an insurer shall notify policyholders at least 30 days before the due date of the premium reflecting the rate increase.

H. On or before the effective date of a substantial premium increase as defined in subsection (F), an insurer shall:

1. Offer the insured the option of reducing policy benefits under the current coverage without additional underwriting so that required premium payments are not increased;
2. Offer to convert the coverage to a paid-up status with a shortened benefit period according to the terms of subsection (I), which the insured may elect at any time during the 120-day period referenced in subsection (F)(2); and
3. Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in subsection (F)(2) is deemed to be the election of the offer to convert under subsection (H)(2).

I. In this Section, "benefits continued as nonforfeiture benefits," including contingent benefits upon lapse, mean any of the following:

1. Attained age rating is defined as a schedule of premiums starting from the issue date that increases age at least one percent per year before age 50, and at least three percent per year beyond age 50.
2. The nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in subsection (I)(3).
3. The standard nonforfeiture credit equals 100% of the sum of all premiums paid, including the premiums paid before any change in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. The minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subsection (J).

4. The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three years, and thereafter.
5. Notwithstanding subsection (I)(4), for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:
   a. The end of the tenth year following the policy or certificate issue date; or
   b. The end of the second year following the date the policy or certificate is no longer subject to attained age rating.
6. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

J. All benefits paid by the insurer while the policy or certificate is in premium-paying status and in the paid- up status shall not exceed the maximum benefits that would be payable if the policy or certificate had remained in premium-paying status.

K. There shall be no difference in the minimum nonforfeiture benefits for group and individual policies.

L. The requirements in this Section are effective on or after November 10, 2005 and shall apply as follows:
1. Except as provided in subsection (L)(2), this Section applies to any long-term care policy issued in this state on or after January 10, 2005.
2. The provisions of this Section do not apply to certificates issued on or after January 10, 2005, under a group long-term care insurance policy as defined in A.R.S. § 20-1691(5)(a), that was in force on January 10, 2005.

M. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of R20-6-1014, treating the policy as a whole.

N. To determine whether contingent nonforfeiture upon lapse provisions are triggered under subsection (F), a replacing insurer that purchased or otherwise assumed a block of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium the insured paid when first buying the policy from the original insurer.

O. An insurer shall offer a nonforfeiture benefit for a qualified long-term care insurance contract that is a level premium contract and the benefit shall meet the following requirements:
1. The nonforfeiture provision shall be separately captioned using the term "nonforfeiture benefit" or a substantially similar caption.
2. The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the insurer may adjust the amount of the benefit initially granted only as needed to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the Director under to A.R.S. § 20-1691.08 for the same contract form; and
3. The nonforfeiture provision shall provide at least one of the following:
   a. Reduced paid-up premiums,
   b. Extended term insurance,
   c. Shortened benefit period; or
   d. Other similar offerings that the Director has approved.

R20-6-1020. Standards for Benefit Triggers

A. A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Except as otherwise provided in R20-6-1021, eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.

B. Activities of daily living shall include at least the following as defined in R20-6-1003 and in the policy:
1. Bathing;
2. Continence;
3. Dressing;
4. Eating;
5. Toileting; and
6. Transferring;

C. An insurer may use additional activities of daily living to trigger covered benefits if the activities are defined in the policy.

D. An insurer may use additional provisions to determine when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements in subsections (A) and (B).

E. For purposes of this Section the determination of a deficiency shall not be more restrictive than:
1. Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or
2. If the deficiency is due to the presence of a cognitive impairment, requiring supervision or verbal cueing by another person to protect the insured or others.

F. Licensed or certified professionals, such as physicians, nurses or social workers, shall perform assessments of activities of daily living and cognitive impairment.

G. The requirements in this Section are effective on and after November 10, 2005 and shall apply as follows:
1. Except as provided in subsection (G)(2), the provisions of this Section apply to a long-term care policy issued in this

state on or after January 10, 2005.

2. The provisions of this Section do not apply to certificates issued on or after January 10, 2005, under a long-term care insurance policy issued to a group as defined in A.R.S. § 20-1691(5)(a), which policy was in force on January 10, 2005.

R20-6-1021. Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts

A. A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided under a plan of care prescribed by a licensed health care practitioner.

B. A qualified long-term care insurance contract shall condition the payment of benefits on a certified determination of the insured's inability to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity or to severe cognitive impairment.

C. Licensed or certified professionals, including physicians, registered professional nurses, and licensed social workers, shall perform the certified determinations regarding activities of daily living and cognitive impairment required under subsection (B).

D. Certified determinations required under to subsection (B) may be performed at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity and the insured is in claim status, the certified determination may not be rescinded and additional certified determinations may not be performed until after the expiration of the 90-day period.

~~R20-6-1015.~~R20-6-1022. Standard Format Outline of Coverage

~~**A.** The outline of coverage shall be delivered to applicants as required by A.R.S. § 20-1691.04.~~

~~B.~~A. The outline of coverage prescribed in A.R.S. § 20-1691.06 shall be a free-standing document, using no smaller than 10 point type, and shall contain no advertising or promotional material ~~of an advertising nature~~.

~~C.~~B. Text ~~which~~ that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means ~~which provide~~ that give prominence equivalent to ~~such~~ capitalization or underscoring.

~~D.~~C. An insurer shall use ~~Use of~~ the text and sequence of text ~~of~~ in the standard format outline of coverage prescribed in Appendix ~~C~~ J ~~is mandatory~~, unless otherwise specifically indicated.

~~R20-6-1016.~~R20-6-1023. Requirement to Deliver Shopper's Guide

A. All prospective applicants of a long-term care insurance policy or certificate shall ~~be provided~~ receive a long-term care shopper's guide approved by the Director. This requirement may be satisfied by delivery of the current edition of the long-term care shopper's guide in the format developed by the National Association of Insurance Commissioners.

1. In the case of ~~agent~~ insurance producer solicitation, ~~an agent~~ an insurance producer shall deliver the shopper's guide ~~prior to the presentation of~~ before presenting an application or enrollment form.
2. In the case of direct response solicitations, the insurer shall provide the shopper's guide ~~shall be presented in conjunction~~ with any application or enrollment form.

B. A prospective applicant for a life insurance policy or rider containing accelerated long-term care benefits is not required to receive the guide described in subsection A, but shall receive the policy summary required under A.R.S. § 20-1691.06.

R20-6-1024. Instructions for Appendices

Information that is designated as a "Drafting Instruction" in a form appended to this Article is not required to be included as part of the form. Any person using the form shall abide by the instructions when drafting, preparing, or completing the form.

APPENDIX A

Long-term Care Insurance

Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers_____

The premium for the coverage you are considering will be [$_____ per month, or $_____ per year,] [a one-time single

premium of $_____.]

Type of Policy (noncancellable/guaranteed renewable): _____

The Company's Right to Increase Premiums: _____
[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

Rate Increase History
The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.]

(Drafting Instruction: A company may use the first bracketed sentence above only if it has never increased rates under any prior policy forms in this state or any other state. The issuer shall list each premium increase it has instituted on this or similar policy forms in this state or any other state during the last 10 years. The list shall provide the policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The insurer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The insurer may provide, in a fair manner, additional explanatory information as appropriate.)

Questions Related to Your Income

How will you pay each year's premium?
☐From my Income ☐From my Savings/Investments ☐My Family will Pay

[☐ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?]

(Drafting Instruction: The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.)

What is your annual income? (check one)☐Under $10,000 ☐$[10-20,000] ☐$[20-30,000] ☐$[30-50,000] ☐Over $50,000

(Drafting Instruction: The issuer may choose the numbers to put in the brackets to fit its suitability standards.)
How do you expect your income to change over the next 10 years? (check one)

☐No change ☐Increase ☐Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ☐ Yes ☐ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?
☐From my Income ☐From my Savings/Investments ☐My Family will Pay

The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

(Drafting Instruction: The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.)

What elimination period are you considering? Number of days _____ Approximate cost $_____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

☐From my Income ☐From my Savings/Investments ☐My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

☐Under $20,000 ☐$20,000-$30,000 ☐$30,000-$50,000 ☐Over $50,000

How do you expect your assets to change over the next ten years? (check one)

☐Stay about the same ☐Increase ☐Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

☐	The answers to the questions above describe my financial situation.
	or
☐	I choose not to complete this information.
	(Check one.)

☐	I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** (This box must be checked).

Signed:_____ _____
(Applicant) (Date)

[☐ I explained to the applicant the importance of completing this information.

Signed:_____ _____
(Insurance Producer) (Date)

Insurance Producer's Printed Name:_____]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed:_____ _____
(Applicant) (Date)

(Drafting Instruction: Choose the appropriate sentences depending on whether this is a direct mail or insurance producer sale.)
The company may contact you to verify your answers.
(Drafting Instruction: When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.)

APPENDIX B

Long-term Care Insurance

Potential Rate Increase Disclosure Form

Instructions:
This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.
Insurers shall provide all of the following information to the applicant:

Long-term Care Insurance

Potential Rate Increase Disclosure Form

1. **[Premium Rate] [Premium Rate Schedules]**: [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and [approved] for an increase [is][are] [on the application][$_____])
2. **The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.**
3. **Rate Schedule Adjustments:**
   The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): **_____.**
4. **Potential Rate Revisions:**
   This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

Contingent Nonforfeiture

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:
You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

Turn the Page

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you have paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be con-

sidered "paid-up" with no further premiums due.

Example:

• You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.
• In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).
• Your "paid-up" policy benefits are $10,000 (provided you have a least $10,000 of benefits remaining under your policy.)

Turn the Page

Contingent Nonforfeiture
Cumulative Premium Increase over Initial Premium
That qualifies for Contingent Nonforfeiture
(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	**Percent Increase Over Initial Premium**
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%

85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

APPENDIX ~~A~~ C

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ~~ACCIDENT AND SICKNESS~~ HEALTH OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing ~~accident and sickness~~ health or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides [thirty (30)] ~~[ten (10)]~~ days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all ~~accident and sickness~~ health or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY ~~AGENT~~ [~~BROKER~~ INSURANCE PRODUCER OR OTHER REPRESENTATIVE]:

(Use additional sheets, as necessary.)

I have reviewed ~~our~~ your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations which I call to your attention:

1. Health conditions ~~which~~ that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, ~~whereas~~ even though a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probation periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its ~~agent~~ insurance producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been property recorded.

(Signature of ~~Agency, Broker~~ Insurance Producer or Other Representative) (Company Name)

(Typed Name and Address of ~~Agent or Broker~~ Insurance Producer)

The above "Notice to Applicant" was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

APPENDIX ~~B~~ D

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ~~ACCIDENT AND SICKNESS~~ HEALTH OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing ~~accident and sickness~~ health or long-term care insurance and replace it with the long-term care insurance policy being delivered ~~herein~~ and issued by [company name] Insurance Company. Your new policy ~~provides~~ gives you thirty (30) days ~~within which you may~~ to decide, without cost, whether you ~~desire~~ want to keep the policy. For your own information and protection, you should be aware of and seriously consider certain facts which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all ~~accident and sickness~~ health coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, ~~whereas~~ even though a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly, Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

[COMPANY NAME]

APPENDIX E

Long-term Care Insurance

Replacement and Lapse Reporting Form

For the State of _____

For the Reporting Year of _____

Company Name:_____Due: June 30 annually
Company Address:_____Company NAIC Number: _____
Contact Person:_____Phone Number: (____)_____

Instructions

The purpose of this form is to report on a statewide basis information regarding long-term care insurance policy replacements and lapses. Every insurer shall maintain the following records for each insurance producer: (1) amount of long-term care insurance replacement sales as a percent of the insurance producer's total annual sales and (2) the amount of lapses of long-term care insurance policies sold by the insurance producer as a percent of the insurance producer's total annual sales. The tables below should be used to report the ten percent (10%) of the insurer's insurance producers with the greatest percentages of replacements and lapses.

Listing of the 10% of Insurance Producers with the Greatest Percentage of Replacements

Insurance Producer's Name	Number of Policies Sold By This Insurance Producer	Number of Policies Replaced By This Insurance Producer	Number of Replacements as % of Number of Policies Sold By This Insurance Producer

Listing of the 10% of Insurance Producers with the Greatest Percentage of Lapses

Insurance Producer's Name	Number of Policies Sold By This Insurance Producer	Number of Policies Lapsed By This Insurance Producer	Number of Lapses As % of Number Sold By This Insurance Producer

Company Totals

Percentage of Replacement Policies Sold to Total Annual Sales ____%
Percentage of Replacement Policies Sold to Policies In Force (as of the end of the preceding calendar year) ____%
Percentage of Lapsed Policies to Total Annual Sales _____%
Percentage of Lapsed Policies to Policies In Force (as of the end of the preceding calendar year) _____%

APPENDIX F

Long-term Care Insurance

Claims Denial Reporting Form

For the State of_____

For the Reporting Year of_____

Company Name:_____ Due: June 30 annually
Company Address:_____
_____
Company NAIC Number:_____
Contact Person:_____Phone Number:_____
Line of Business:Individual Group

Instructions

The purpose of this form is to report all long-term care claim denials under in-force long-term care insurance policies. "Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

		State Data	**Nationwide Data**[1]
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7	Number of Long-Term Care Claim Denied due to:		
8	• Long-Term Care Services Not Covered under the Policy[2]		
9	• Provider/Facility Not Qualified under the Policy[3]		
10	• Benefit Eligibility Criteria Not Met[4]		
11	• Other		

1. The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.
2. Example—home health care claim filed under a nursing home only policy.
3. Example—a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
4. Examples—a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

APPENDIX G

RESCISSION REPORTING FORM FOR

LONG-TERM CARE POLICIES

FOR THE STATE OF _____

FOR THE REPORTING YEAR _____

Company Name_____
Address:_____
_____
Phone Number:_____
Due: March 1 annually

Instructions:

The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission:
_____
_____
_____
_____

Signature
_____
Name and Title (please type)
_____
Date

APPENDIX H

Things You Should Know Before You Buy

Long-Term Care Insurance

Long-Term Care Insurance	• A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
	• [You should **not** buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]

(Drafting Instruction: For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.)

	• The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.
Medicare	• Medicare does **not** pay for most long-term care.
Medicaid	• Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
	• Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
	• When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
	• Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.
Shopper's Guide	• Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.
Counseling	• Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

APPENDIX I

Long-Term Care Insurance Suitability Letter

Dear [Applicant]:
Your recent application for long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

(Drafting Instruction: Choose the paragraph that applies.)

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

☐ Yes, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

Drafting Instruction: Delete the phrase in brackets if the applicant did not answer the questions about income.

☐ **No.** I have decided not to buy a policy at this time.

_____ _____
APPLICANT'S SIGNATURE DATE

Please return to [issuer] at [address] by [date].

APPENDIX ~~C~~ J

[COMPANY NAME]

[ADDRESS - CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, ~~must~~ shall appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] ~~(~~[certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] [a group policy] which was issued in the [indicate jurisdiction in which group policy was issued].

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. FEDERAL TAX CONSEQUENCES

This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance contract under Section 7702(B)(b) of the Internal Revenue Code of 1986, as amended.

or

Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE].is not intended to be a federally tax-qualified long-term care insurance contract under Section 7702(B)(b) of the Internal Revenue Code of 1986, as amended. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED

(a) [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:

(1) Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) [Policies and certificates that are noncancellable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

(b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]

(c) [Describe waiver of premium provisions or state that there are not such provisions;]

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS

[In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

~~3~~6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return - "free look" provision of the policy.]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund

of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

~~4.~~7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) [For ~~agents~~ insurance producers] Neither [insert company name] nor its [agents or insurance producers] represent Medicare, the federal government or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

~~5.~~8. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for ~~1~~ one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute-care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

~~6~~ 9. BENEFITS PROVIDED BY THIS POLICY

(a) [Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Non-institutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be defined and described as part of the outline of coverage.]

[Any additional benefit ~~screens must~~ triggers shall be explained in this Section. If these ~~screens~~ triggers differ for different benefits, explanation of the ~~screen should~~ triggers shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. ~~If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.~~]

~~7.~~10. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Non-eligible ~~facilities/provider~~ facilities and providers;

(c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) ~~Exclusions/exceptions~~ Exclusions and exceptions;

(e) Limitations.]

[This Section ~~should~~ shall provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in paragraph 6 above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

~~8.~~11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. ~~(~~[As applicable, indicate the following:

(a) That the benefit level will not increase over time;

(b) Any automatic benefit adjustment provisions;

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

(e) ~~And finally, describe~~ Describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

~~9. TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED.~~

~~[(a) Describe the policy renewability provisions;~~

~~(b) For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;~~

~~(c) Describe waiver of premium provisions or state that there are not such provisions;~~

~~(d) State whether or not the company has a right to change premium and, if such a right exists, describe clearly and concisely each circumstance under which premium may change.]~~

~~10.~~12.ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related

degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

~~11.~~13. PREMIUM.

[(a) State the total annual premium for the policy;

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

~~12.~~14. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.